ARCHDIOCESE OF MILWAUKEE

Form
5140.2(b)

Medical Provider Authorization Form
Prescription Medication

Student's Name: _____ Date of birth: _____

School: _____Grade:_____

Diagnosis: _____

Daily Medication

Medication	Dosage	Route	Frequency	Start Date	Stop Date	Side Effects
1.						
2.						

As Needed or PRN Medication

Medication	Dosage	Route	Frequency	Start Date	Stop Date	Side Effects
1.						
2.						

Medical Provider Consent

I authorize the school to the give the above medication(s) to this student.

Asthma Inhalers and Epi-Pens Only: This student and his/her parents have been instructed in self-administration and the student may carry an inhaler or Epi-Pen and self administer at school. Yes_____ No_____

Print Medical Provider Name: _____ Phone _____

Medical Provider Signature: _____Date:_____

Parent Consent

I give the school permission to administer the above medications as directed by the medical provider.
Inhaler/Epi-Pen Only: My child may _____ or may not _____ carry and self administer.

Parent/Guardian Signature: _____ Date: _____

As part of the authorization form, school personnel may contact the medical provider and parent with questions regarding the medication administration including clarification regarding dosage, side effects or indication of the medication(s) listed above.